STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445445	A. BUILDING _____ B. WING _____	07/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CELINA HEALTH AND REHABILITATION CENTER	120 PITCOCK LANE CELINA, TN 38551

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to implement a Gradual Dose Reduction (GDR) ordered by the physician for one resident (#79) of five residents reviewed for unnecessary medications. The finding included: Resident #79 was admitted to the facility on	F 329	This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding. F329 1. On 7/8/14, the Charge Nurse clarified with the MD the order for a gradual dose reduction (GDR) from Abilify 5 milligrams to Abilify 2.5 milligrams for seven days then discontinue. The physician and the responsible party were notified by the Charge Nurse on 7/8/14 regarding the resident not receiving the GDR in the Abilify on April 9, 2014 as ordered. 2. An audit of all Medication Administration Records and all Physician Orders was completed on 7/11/14 by the	Completion Date 7/18/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paula Boone — TITLE: Administrator — (X6) DATE: 7/23/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JUL 24 2014

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F 329	Continued From page 1 November 1, 2013, with diagnoses including Chronic Obstructive Pulmonary Disease, Dementia with Delusions, Psychosis, Anxiety, and Depressive Disorder. Medical record review of the Consultant Pharmacist Communication to the Physician dated March 2014, revealed the pharmacist recommended a GDR for Abilify (antipsychotic) from 5 milligrams to 2.5 milligrams. Continued review revealed the physician approved the recommendation as indicated by a check mark in the "...I AGREE: Please write order(s)...", and signed by the Physician on April 9, 2014. Medical record review of the Medication Administration Record (MAR) for April, May, and June 2014, revealed the recommended dosage reduction had not been implemented. Interview with the Director of Nursing (DON) on July 8, 2014, at 3:33 p.m., in the DON's office, confirmed the Pharmacist's recommendation (agreed upon by the Physician) had not been transcribed as a Physician's order, and implemented in the resident's medication regimen.	F 329	Staffing Coordinator and the QA Nurse. No other residents were identified as having been affected. 3. All Licensed Nurses were in serviced from 7/11/14 to 7/18/14 by the Director of Nursing regarding proper medication administration procedures. 4. The Director of Nursing will audit five charts per week for four weeks then fifteen times per month for two months or until 100% compliance is achieved. All results will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement committee comprised of the Medical Director, Administrator, Director of Nursing, Staffing Coordinator, Minimum Data Set Coordinator, Social Services, Activities Director, Dietary Manager, and Housekeeping Supervisor.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

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F 431	Continued From page 2 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to dispose of expired medications in one of one medication storage rooms observed. The findings included: Observation in the medication storage room on July 8, 2014, at 1:55 p.m., revealed eleven, one hundred unit (5 milliliter) heparin (blood thinner) syringes with an expiration date of July 1, 2014, in	F 431	F431 1. The expired Heparin Lock vials were removed and discarded by the Director of Nursing on 7/8/14. Resident # 71 was assessed by the licensed nurse and the physician on 7/8/14. No adverse outcomes noted. 2. All Heparin Lock vials were audited to ensure they were not expired by the Director of Nursing and the Staffing Coordinator on 7/8/14. No other vials were found to be affected. 3. Licensed Nurses were in-serviced by the Director of Nursing from 7/8/14 – 7/15/14 on Heparin Lock Vials expiration dates. 4. An audit of 5 Heparin Lock vials will be conducted weekly for 4 weeks, then monthly for 2 months and/or 100% compliance by the Director of Nursing and the Staffing Coordinator. The results of the audits will be presented by the Director of Nursing to the Quality Assurance/Performance Improvement Committee for 3 months and/or until	Completion Date 7/18/14

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F 431	Continued From page 3 the cabinet. Review of the facility policy, Storage of Medications, effective date June 2011, revealed, "Outdated...medications...are immediately removed from stock...and reordered from the pharmacy..." Interview with the Director of Nursing (DON) on July 8, 2014, at 1:55 p.m., in the medication storage room, confirmed the heparin syringes had expired and had not been disposed of in a timely manner.	F 431	substantial compliance is achieved. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.	